

ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD
9535 E. DOUBLETREE RANCH ROAD, SUITE 100, SCOTTSDALE, AZ 85258
PHONE (602) 364-1PET (1738) FAX (602) 364-1039
VETBOARD.AZ.GOV

COMPLAINT INVESTIGATION FORM

If there is an issue with more than one veterinarian please file a separate Complaint Investigation Form for each veterinarian

PLEASE PRINT OR TYPE

FOR OFFICE USE ONLY

Date Received: Nov 9, 2017

Case Number: 18-33

A. THIS COMPLAINT IS FILED AGAINST THE FOLLOWING:

Name of Veterinarian/CVT: Kristen Hale

Premise Name: Pet Doctor

Premise Address: 6464 N Oracle rd

City: Tucson State: AZ Zip Code: 85704

Telephone: (520) 829-5166

B. INFORMATION REGARDING THE INDIVIDUAL FILING COMPLAINT*:

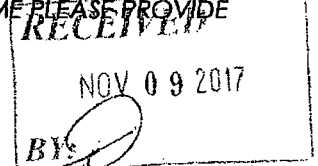
Name: Emily Hall

Address: [REDACTED]

City: [REDACTED] State: [REDACTED] Zip Code: [REDACTED]

Home Telephone: _____ Cell Telephone: [REDACTED]

*STATE LAW REQUIRES WE HAVE TO DISCLOSE YOUR NAME UNLESS WE CAN SHOW THAT DISCLOSURE WILL RESULT IN SUBSTANTIAL HARM TO YOU, SOMEONE ELSE OR THE PUBLIC PER A.R.S. § 41-1010. IF YOU HAVE REASON TO BELIEVE THAT SUBSTANTIAL HARM WILL RESULT IN DISCLOSURE OF YOUR NAME PLEASE PROVIDE COPIES OF RESTRAINING ORDERS OR OTHER DOCUMENTATION.



C. PATIENT INFORMATION (1):

Name: Marley
Breed/Species: Pitbull Mix/ Dog
Age: 1 Sex: female Color: black/white

PATIENT INFORMATION (2):

Name: _____
Breed/Species: _____
Age: _____ Sex: _____ Color: _____

D. VETERINARIANS WHO HAVE PROVIDED CARE TO THIS PET FOR THIS ISSUE:

Please provide the name, address and phone number for each veterinarian.

Kristen Hale
6464 N Oracle rd
Tucson, AZ 85704
5208295166

E. WITNESS INFORMATION:

Please provide the name, address and phone number of each witness that has direct knowledge regarding this case.

Logan Saindon 

Not aware of nurses names that assisted

Attestation of Person Requesting Investigation

By signing this form, I declare that the information contained herein is true and accurate to the best of my knowledge. Further, I authorize the release of any and all medical records or information necessary to complete the investigation of this case.

Signature: _____

Date: _____

F. ALLEGATIONS and/or CONCERNS:

Please provide all information that you feel is relevant to the complaint. This portion must be either typewritten or clearly printed in ink.

Prior to May 31st 2017 I made an appointment with pet doctor for my one year of dog to be spayed. While setting up the procedure for Marley I had several questions, one being if it was okay for Marley to be spayed while she was in heat, the lady I was speaking to said she would have to check with the doctor. She placed me on hold, when she returned to call she stated that it was fine, and would not be a problem. I brought Marley in at the time she was scheduled, and picked her up around 330 pm. She was having a extremely hard time walking. I made sure with everything was okay with them and took Marley home. She seemed very lethargic and I assume this was due to the anesthesia. She had drank a little water, and I did not think anything was out of the ordinary for the procedure she had done.

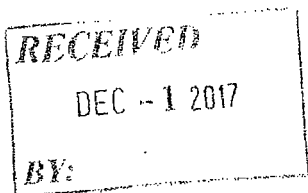
I was told to bring her in the next day to have her stomach bandages taken off, that were on due to oozing and bleeding. I took her in, I had to carry her in because she had to struggle to walk. I brought her into the room for them to examine her. I told the nurse she still seemed out of it, the nurse said she should not be like that at this point of the day but she had to speak to the doctor. The nurse then said they were going to take her to the back to examine everything and take her bandages off. Then a couple minutes later the doctor came in and stated that she wanted to keep Marley until the end of their business day for observation. I then asked was this serious. Should I be concerned and wait for more news? She said NO not at all. She then told me to come back and pick her up around 530 pm

I did not get the opportunity to pick her up because the doctor called me about two hours after I left, to let me know Marley was not doing good at all, that she was having a tough time breathing and they had to intubate her. She proceeded to tell me that her heart was failing and that she was possibly bleeding internally. They gave her heart compressions and three rounds of epi, and at that point I was told there was nothing else that could be done and that usually at this point they stop working on Marley. While I was unable to get to the clinic my boyfriend, Marley's other owner, came to check on her and was treated very rudely and was denied to see her at one point.

I do not understand why I was not told that her being in heat could have resulted in her death while being spayed. I trusted the information provided. They also provided her to be cremated for free of charge.

When I finally picked Marley up, after being cremated, I asked for the paper work on her. The nurse then walked to the back and took 9 minutes to get the paper work approved by the doctor to be able to give to me. I had to sympathize, no compassion given to me.

I have send a formal letter to the company for an explanation of her death and I recieved no response.



18-33

Kristen Hale, DVM, Msc
Pet Doctor
Tucson, AZ
Case 18-33

This is in regards to the case involving Marley, owned by Emily Hall.

Marley was a 1 year old female pit bull mix that presented for a spay procedure on May 31, 2017. Prior to this day, no knowledge was had of this patient in regards to questions asked when making the appointment for the surgery.

At the time of surgery Marley was showing signs of being in heat (swollen vulva and enlarged mammary chain) but she appeared otherwise healthy. The surgery was unremarkable. I was assisted by Dr Nelson during the procedure because of the size of the patient and her being in heat/higher risk. She had some bleeding from her skin while closing so electrocautery was used along with the placement of a pressure wrap around her abdomen which was to be removed the following day.

The following day, Ms Hall returned with Marley shortly before noon. Marley was still sedate and was reluctant to stand or walk on her own. After being placed in an exam room, I was alerted of her condition and requested that they bring her back to the treatment area so we could remove her bandage and I could check her closer. She was carried to the back. Her bandage was removed – the incision appeared to be in good condition. Centesis was attempted on her abdomen to rule out internal bleeding secondary to the spay the previous day. No blood was found on aspirate of multiple locations. Her color was pink and her heart rate and respiratory rate was normal. Blood pressure was 120/84 and PCV was 32%. At that time we believed it to be a reaction to the anesthesia from the previous day. I discussed this with Ms Hall at that time and recommended keeping her on IV fluids for the day so we could monitor her. I advised her that this level of sedation was not normal 24 hours after an anesthetic event but that we did not find evidence of anything more severe (abdominal bleeding) at this time. Discussed coming back to pick up Marley around 5-5:30 that evening. She said that she would not be able to but that her boyfriend, Logan Sandon, would pick up. She approved of the plan for the day and we got Marley settled in with an IV catheter and fluids running.

Marley appeared comfortable but remained sedate for the next few hours. Around 3pm, it was noted that she began vomiting a dark, almost bloody, fluid. Concern was raised for a reaction to either the ketoprofen injection the prior day, or to the carprofen she was meant to have been given that morning. At that time, we attempted to contact the owners and discussed the concern for the bloody vomitus. While on the phone, another abdominocentesis was attempted and showed to be positive for bleeding this time. Immediately after finding this, Marley was taken to surgery and was prepped for an exploratory to find the source of the bleeding. No bleeding was found from any of the remnants but a tear was noted at the body wall attachment of the right ovarian pedicle. While suturing this area, Marley stopped breathing on her own. The isoflurane was decreased and manual ventilation was provided. Prior to being able to close Marley's abdomen, she went into cardiac arrest. Several doses of epinephrine and 1 dose of atropine were given along with chest compressions. We were not able to get Marley's stabilized. I was unable to contact Ms Hall during this time to discuss what was happening in surgery so I attempted to contact her boyfriend, Mr Sandon. While on the phone with him, he became aggressive and said he was coming down to the clinic. We continued to work on Marley until Ms Hall was contacted. I discussed with her what we had found in surgery and that we were trying to resuscitate Marley at this time but we were not getting any response. She requested that we try one additional round of medications (epinephrine) for a few more minutes. We accepted this and attempted but still did not get a response. During this time, Mr Sandon presented to the clinic. He was in the lobby yelling that we had killed his dog and being aggressive towards staff. He requested to see Marley at that time but was declined because she was still open on the surgery table. Ms Hall was contacted again to let her know that we were still unable to regain a heart beat on Marley and we did not advise to continue resuscitation efforts.

After discussing with Ms Hall, Mr Sandon was put into an exam room so that we could discuss with him everything that was found and done and so that he could visit Marley. He was calm in the room while discussing the case with me. After this time, Marley was brought in for him to visit. During this time his brother also presented to the clinic and they became combative with staff again. The sheriff's department was contacted due to the escalating threats being made.

After they left, this was the last I heard details of this case. Arrangements were made for private cremation at no cost to the client. When reviewing the file prior to submitting these documents, it appears the owner sent a letter. Our hospital manager provided a written response which was mailed to the address we had on file. This letter was returned to us as not being deliverable.

In response to the statement that she called to ask questions about spaying in heat dog, I do not know if this is true or not. At no time was I asked by any of the reception staff about the risks associated with this procedure. Generally as a hospital, we do not recommend spaying while in heat due to the risks but will do so if the owner insists. We have since started having owners sign off that they understand the risks of spaying while in heat so that we do not run into this situation again.

DOUGLAS A. DUCEY
- GOVERNOR -



VICTORIA WHITMORE
- EXECUTIVE DIRECTOR -

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INVESTIGATIVE COMMITTEE REPORT

TO: Arizona State Veterinary Medical Examining Board

FROM: PM Investigative Committee: Adam Almaraz - Chair
Amrit Rai, D.V.M.
Donald Noah, D.V.M.
Christine Butkiewicz, D.V.M.
Tamara Murphy

STAFF PRESENT: Tracy A. Riendeau, CVT – Investigations
Sunita Krishna – Assistant Attorney General
Victoria Whitmore, Executive Director

RE: Case: 18-33
Complainant(s): Emily Hall
Respondent(s): Kristen Hale, DVM (License: 6538)

SUMMARY:

Complaint Received at Board Office: 11/9/17
Committee Discussion: 2/6/18
Board IIR: 3/21/2018

APPLICABLE STATUTES AND RULES:

Laws as Amended July 2014
(Salmon); Rules as Revised September
2013 (Yellow)

On May 31, 2017, "Marley," a 1-year-old female Pit Bull mix was presented to Respondent for a spay procedure. The procedure was performed and the dog was discharged later that day.

The following day, the dog returned to Respondent for a recheck due to the dog's lethargy. The dog remained in the hospital for observation – it was determined the dog was having internal bleeding and exploratory surgery was performed. A tear was noted at the body wall attachment of the right ovarian pedicle. While suturing this area, the dog arrested. Resuscitation efforts were unsuccessful and the dog passed away.

Complainant contends Respondent was negligent in the care of the dog.

Complainant was noticed and appeared.
Respondent was noticed and appeared telephonically.

The Committee reviewed medical records, testimony, and other documentation as described below:

- Complainant(s) narrative: *Emily Hall*
- Respondent(s) narrative/medical record: *Kristen Hale, DVM*

PROPOSED 'FINDINGS of FACT':

1. On May 31, 2017, the dog was presented to Respondent for a spay procedure. According to Complainant, she had contacted the premise previously to ensure it would be safe to spay the dog while she was in heat and was told it was fine. Respondent stated that she was unaware of Complainant's call to the premise to discuss possible complications of spaying a dog in heat.
2. Upon exam, the dog was showing signs of heat due to a swollen vulva and enlarged mammary chain but appeared otherwise normal. The dog had a weight = 61.3 pounds, a temperature = 100.9 degrees, a pulse rate = 120bpm and a respiration rate = 50rpm.
3. The dog was pre-medicated with 3mLs of atropine and acepromazine (amount of each is unknown), induced with ketamine and midazolam and maintained on isoflurane. The dog was administered ketoprofen 0.55mLs SQ and Pen G 3mLs SQ (no concentration noted for either medication). The dog was discharged later that day with Carprofen 100mg, 4 tablets, ½ tablet every 12 hours. Instructions to return the next day to remove the bandage were relayed to Complainant.
4. According to Respondent, the spay surgery was unremarkable. There was some bleeding from the skin while closing so electrocautery was used along with a pressure wrap around the abdomen.
5. The following day, Complainant presented the dog to Respondent. She had to carry the dog into the premise due to lethargy. Upon exam, the dog had a weight = 62.3 pounds, a temperature = 99 degrees, a pulse rate = 130rpm and a respiration rate = 30rpm. Due to the dog's lethargy, Respondent recommended keeping the dog at the premise for observation; Complainant agreed.
6. Abdominal aspiration revealed no blood; blood pressure 120/84; and PCV = 32%, total protein = 1.35. An IV catheter was placed and fluids were initiated (type unknown), 400mLs bolus.
7. A few hours later, the dog began vomiting dark, blood-like fluid. Respondent was concerned the dog may be having a reaction to the ketoprofen administered the previous day or to the Carprofen that was dispensed. Another abdominocentesis was performed and was positive for bleeding. The dog was immediately taken into surgery to find the source of bleeding – no bleeding was found from any of the remnants but a tear was noted at the body wall attachment of the right ovarian pedicle. While suturing this area, the dog went into a respiratory arrest – isoflurane was decreased and ventilation was provided; the dog then went into cardiac arrest. Unclear if Complainant authorized the emergency exploratory.
8. Resuscitation efforts were started via chest compressions and injections of epinephrine. Respondent was unable to stabilize the dog and attempted to contact Complainant – she was

not available therefore Respondent contacted Complainant's boyfriend who said he was heading to the premise. When Complainant was contacted and made aware of the situation, she requested Respondent make another attempt to save the dog; more epinephrine was administered. An additional attempt was made without success. After the dog died, she was placed in an exam room for Complainant's boyfriend to visit. He became combative and the police were contacted due to escalating threats.

9. Complainant stated that she send a letter to the premise for an explanation of the dog's death and did not receive a response. According to Respondent, the hospital manager provided a written response which was mailed to the address on file. The letter was returned as not being deliverable.

COMMITTEE DISCUSSION:

The Committee discussed concerns that Complainant was not advised of the risks of spaying an animal in heat as well as the communications of staff answering questions about an animal in heat without consulting a veterinarian. Additionally, there did not seem to be attempts to determine why the dog was having bloody vomit as it did not seem like it was the result of the carprofen. The dog was administered ketoprofen and discharged with carprofen – however a necropsy was not performed and it is not known if Complainant administered the carprofen.

The Committee expressed concern that the dog was able to be intubated on June 1, 2017 without induction, which indicates the dog was moribund. They were concerned a dog with post-surgical complications was not monitored closely. Even though this situation was an emergency and Complainant was not charged for the surgery, Respondent did not obtain authorization to perform surgery on the dog.

The Committee noted some medical record keeping issues.

COMMITTEE'S PROPOSED CONCLUSIONS of LAW:

The Committee concluded that possible violations of the *Veterinary Practice Act* occurred.

COMMITTEE'S RECOMMENDED DISPOSITION:

Motion: It was moved and seconded the Board find:

ARS § 32-2232 (21) as it relates to AAC R3-11-502 (H) (1) failure to obtain signed authorization from the animal owner, or verbal authorization that is witnessed by one other individual, prior to surgery being performed on June 1, 2017.

ARS § 32-2232 (21) as it relates to AAC R3-11-502 (L) (7) (b) failure to document the amount of atropine and acepromazine administered to the dog on May 31, 2017.

ARS § 32-2232 (12) as it relates to AAC R3-11-501 (1) failure to provide professionally acceptable procedures for not monitoring the dog closely; the dog was moribund to the point that she was able to be intubated without sedation or induction on June 1, 2017.

Vote: The motion was approved with a vote of 5 to 0.

The information contained in this report was obtained from the case file, which includes the complaint, the respondent's response, any consulting veterinarian or witness input, and any other sources used to gather information for the investigation.

Tracy A. Riendeau, CVT
Investigative Division

DOUGLAS. A DUCEY
GOVERNOR



VICTORIA WHITMORE
EXECUTIVE DIRECTOR

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IN ACCORDANCE WITH § A.R.S. 32-2237(D): "IF THE BOARD REJECTS ANY RECOMMENDATION CONTAINED IN A REPORT OF THE INVESTIGATIVE COMMITTEE, IT SHALL DOCUMENT THE REASONS FOR ITS DECISION IN WRITING."

At the April 18, 2018 meeting of the Arizona State Veterinary Medical Examining Board, the Board conducted an Informal Interview in Case 18-33, In Re: Kristen Hale, DVM.

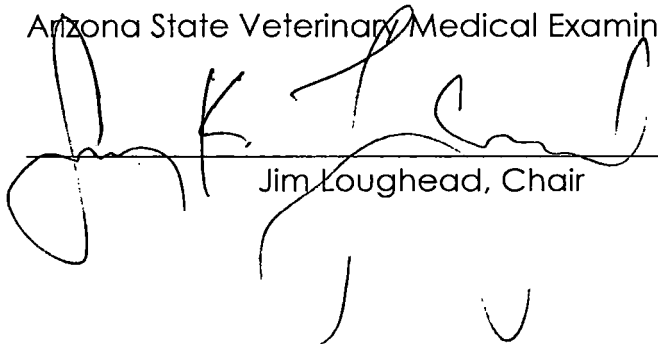
The Board considered the Investigative Committee Findings of Fact, Conclusions of Law, and Recommended Disposition:

1. ARS § 32-2232 (21) as it relates to AAC R3-11-502 (H) (1) failure to obtain signed authorization from the animal owner, or verbal authorization that is witnessed by one other individual, prior to surgery being performed on June 1, 2017.
2. ARS § 32-2232 (21) as it relates to AAC R3-11-502 (L) (7) (b) failure to document the amount of atropine and acepromazine administered to the dog on May 31, 2017.
3. ARS § 32-2232 (12) as it relates to AAC R3-11-501 (1) failure to provide professionally acceptable procedures for not monitoring the dog closely; the dog was moribund to the point that she was able to be intubated without sedation or induction on June 1, 2017.

Following the Informal Interview with Respondent, the Board concluded that 1) Respondent did not need to obtain authorization to perform emergency surgery on a dog she had authority to treat; 2) the medications were documented in the medical record sufficiently; and 3) the dog was monitored closely, therefore voted to dismiss this issue with no violation.

Respectfully submitted this 16TH day of May, 2018.

Arizona State Veterinary Medical Examining Board



Jim Loughhead, Chair